ABOUT YOU CHIROPRACTIC

245 MAIN STREET | SUITE 2M | MATAWAN | NJ | 732-583-0600

Personal and Family Health History

Date _____ Referred By _____

Name _____ Social Security # _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Location _____

Phone (H) _____ Commute by Car / Bus / Train / Other

(C) _____ Marital Status S M D W

Email _____ Spouse's Name _____

Date of Birth _____ (Age) _____ Spouse's Occupation _____

Do you have Children?

Age _____

Age _____

Age _____

Previous Chiropractic Care?

Yes _____ No _____

Yes _____ No _____

Yes _____ No _____

Everyone can benefit from chiropractic care, who would you like to refer?

_____ _____

Name Email/Phone Number

Our bodies are amazing, self-regulating miracles. Unfortunately, through accidents, traumas and stress our spines can accumulate misalignments called subluxations. This will compromise your body's ability to function and stay healthy. Even if it may not seem relevant to your present state please briefly tell us what your spine has been through.

CIRCLE ALL THAT APPLY

Childhood/Teen Years		***Current Health Habits*** *(did/do you...)*			
Was Your Birth Traumatic or Unnatural in Any Way?	Y / N	Fall down the stairs?	Y / N	Have Surgery?	Y / N
Fall out of bed?	Y / N	Experience other traumas?	Y / N	Take Drugs?	Y / N
Bang your head?	Y / N	Emergency room visits?	Y / N	Have mental stress?	Y / N
Prolonged Childhood Illness?	Y / N	Have sleeping problems?	Y / N	Have occupational stress?	Y / N
Have any Accidents?	Y / N	Exercise regularly?	Y / N	Bullied by your siblings?	Y / N

If you answered yes to anything briefly respond: _____

Reason for Your Visit Today _____

Problem Started On _____ Due To _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition interfering with work? _____ Sleep?_____ Routine?_____ Other?_____

Is this condition getting progressively worse? _____

Other Symptoms

□ Headaches	□ Nervousness	□ Buzzing/Ringing in Ears	□ Depression
□ Neck pain/ Stiffness	□ Pins & needles in legs/arms	□ Fainting	□ Constipation
□ Sleeping problems	□ Numbness in fingers /toes	□ Loss of smell/taste	□ Loss of Balance
□ Back pain	□ Shortness of Breath	□ Fatigue	□ Dizziness

Have you been under drug and medical care? _____

What drugs are you taking? _____

How long? _____ Have you had surgery?_____ What?_____ When?_____

What side effects have you experienced from drugs and surgery? _____

Is there a family history of?

Your first visit's purpose is to make sure that we can help you. That depends on if you have a spinal misalignment called a "subluxation." Subluxations cause your body to malfunction. It's our job to determine if you have subluxations and if your subluxations are correctable.

As a result of my chiropractic care, I would like to:

Please check all that apply

□ Feel better quickly

□ Have a healthier spine

□ Have a healthier body by keeping my nerve system healthy

□ Live a healthier lifestyle

_____ _____

Signature Date

QUESTIONAIRRE

Name: _____

Age: _____ Date: _____

THIS IS MEANT TO BE ANSWERED QUICKLY, WITHOUT PONDERING THE ANSWER. YOUR FIRST RESPONSE IS BEST!
Answer the questions below with 5 being the highest and 1 being lowest

1. **How well would you rate your energy level overall?**
   1 2 3 4 5

2. **How well would you rate your quality of sleep?**
   1 2 3 4 5

3. **How well would you rate the function of the following systems?**
   Respiratory system 1 2 3 4 5
   Digestive system 1 2 3 4 5
   Immune system 1 2 3 4 5
   Muscular system 1 2 3 4 5
   Skeletal system 1 2 3 4 5

4. **How well would you rate your overall performance of the following senses?**
   Touch 1 2 3 4 5
   Smell 1 2 3 4 5
   Taste 1 2 3 4 5
   Sight 1 2 3 4 5
   Hearing 1 2 3 4 5

5. **How well would you rate your overall health?** 1 2 3 4 5
6. **How optimistic do you feel about your body's ability to heal itself?** 1 2 3 4 5
7. **How optimistic do you feel about your health in the next 10 years?** 1 2 3 4 5
8. **How motivated do you feel about setting health goals for yourself?** 1 2 3 4 5
9. **How happy are you with your physical appearance?** 1 2 3 4 5
10. **How well would you rate your intent to have a good diet and nutrition?** 1 2 3 4 5
11. **How well would you rate your intent to exercise?** 1 2 3 4 5
12. **Overall, how stress free do you feel your life is?** 1 2 3 4 5
13. **Overall, how stress free do you feel your occupation is?** 1 2 3 4 5
14. **How uncluttered would you say your mental health is?** 1 2 3 4 5
15. **How effective do you think you are at problem solving?** 1 2 3 4 5
16. **How peaceful would you rate your life?** 1 2 3 4 5
17. **How purposeful would you rate your life?** 1 2 3 4 5
18. **How would you rate your happiness?** 1 2 3 4 5